STATE OF NEVADA

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DELEGATION OF AUTHORITY AGREEMENT

The Nevada State Health Division (NSHD) authorizes the following:

( ) Public Health Agency
( ) Public Immunization Clinic
( ) Private Physician
( ) Other__________________________

to provide vaccines on the behalf of our agency through the Vaccines for Children Program (VFC).

Name of Authorized Clinic/Facility ____

Address of Authorized Clinic/Facility ____

____Pin # __________

This agreement will allow the authorized clinic/facility to administer VFC vaccine to children who are underinsured, in addition to those who are Medicaid enrolled, uninsured, Native American or Alaskan Native. Underinsured are considered as a child who has commercial (private) health insurance but the coverage does not include vaccines, a child whose insurance covers only selected vaccines (VFC-eligible for non-covered vaccines only), or a child whose insurance caps vaccine coverage at a certain amount. Once that coverage amount is reached, the child is categorized as underinsured.

This delegation of authority is being supported by Nevada Health Centers (NVHCs). The authorized provider understands that they must enroll in the VFC Program with the NSHD Immunization Program, must adhere to the guidelines and requirements of the VFC Program as delineated by the NSHD, and must properly maintain all VFC vaccines. The NSHD and NVHCs has no legal responsibility for the supervision of immunization services delivered by the authorized clinic/facility. Either party may cease participation in this agreement at any time with written notification prior to the expiration of June 30, 2011. For patients who do not have a source of medical payment, the clinic/facility will supply a sliding fee scale for the office visit. The clinic/facility must report administration of immunizations to the State immunization information system, WebIZ, complete the enrollment forms, and attend trainings.

Print Name of Authorized Provider for Clinic/Facility: ____

Signature of Authorized Provider: ____

Date: ____

BELOW FOR OFFICIAL USE ONLY*

For and on behalf of NSHD: ____

Signature of Administrator: ____

Date: ____